

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was initiated on 09/27/11 and concluded on 09/29/11 with deficiencies cited at the highest scope and severity of an F. A Life Safety Code survey was conducted on 09/28/11 with deficiencies cited at the highest scope and severity of an F.</p>	F 000	<p>F-312: Facility Plan of Correction with a completion date of November 7, 2011</p>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review: Oral Hygiene Policy and Care Plan (undated), it was determined the facility failed to maintain oral hygiene for one (1) of eighteen (18) residents, Resident #2, who was unable to carry out activities of daily living.</p> <p>The findings include: Review of the Oral Hygiene Policy revealed; the purpose of oral hygiene was to cleanse the mouth, teeth and dentures, to prevent infection and irritation of the mouth, to moisten the mucous membranes, and to promote personal hygiene. Review of Resident #2's care plan revealed, Resident #2 was dependent upon staff to provide all activities of daily living (ADL's), related to Resident #2's impaired cognition and mobility.</p>	F 312	<p>1. The facility took specific measures to correct the violation on September 29, 2011. For resident #2 her teeth were brushed immediately on September 29, 2011 by her nurse. Resident #2 care plan was updated by the MDS nurse on September 29, 2011 to include "brush resident teeth twice a day, and any other times as needed". She was also assessed by her nurse on September 29, 2011 for mouth pain which she had none at that time.</p> <p>2. On September 30, 2011 the Quality Assurance nurse did a teeth audit of all residents that care plan stated "dependent on staff to provide all Activities of Daily Living (ADLs)". The audit was conduct to identify those residents that were in need of oral care. If a resident was found in need of oral care it was given immediately on September 30, 2011 by the Quality</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Elsie Magi* TITLE: *X Administrator* (X6) DATE: *10/20/11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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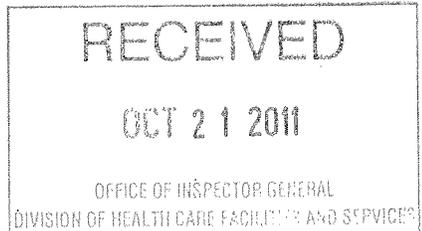
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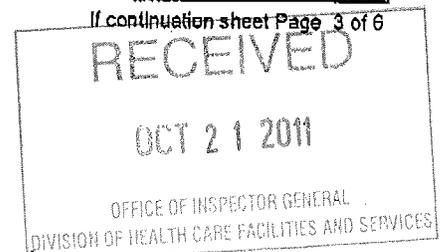
F 312	<p>Continued From page 1</p> <p>Resident #2's co-morbidities were, Cerebral Vascular Accident with Left Hemi-plegia, Right Above the Knee Amputation and Dementia. Resident #2 had a physician's order to have nothing by mouth (NPO) and to receive feedings through a g-tube. The care plan stated staff would anticipate and provide needs and wants for Resident #2 because Resident #2 was unable to voice needs/wants. The care plan goal revealed Resident #2 would be kept clean, dry, comfortable, and appropriately dressed and groomed at all times. Interview with the Unit Coordinator of the B unit, on 09/29/11 at 3:06 PM, revealed all residents needed to have oral care at least twice a day. The care plan approach revealed, nursing staff would assist with all ADL's, including grooming and hygiene for Resident #2.</p> <p>Observation of Resident #2's teeth, on 09/27/11 at 2:44 PM, revealed Resident #2's teeth were caked with a white substance throughout the mouth. No toothettes or toothbrush's were observed at Resident #2's bedside. Observation of Resident #2's teeth, on 09/28/11 at 10:12 AM, revealed a white substance between the resident's teeth crevasses's. No toothettes or toothbrushes were observed at Resident #2's bedside.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/28/11 at 2:38 PM, revealed she had never known Resident #2 to refuse oral care. CNA #1 further stated Resident #2 had a white substance around his/her teeth because of the g-tube feeding.</p> <p>Interview with Resident #2, on 09/29/11 at 2:04 PM, revealed no one had brushed his/her teeth,</p>	F 312	<p>Assurance nurse. If a resident was found to have mouth pain, the pain was assessed for appropriate treatment. If there was a need for a dentist a referral this was made to social services by the Quality Assurance nurse.</p> <p>3. State Registered Nursing Assistants (SRNA) and nurses (RN/LPN) were in-serviced by the Educational director. The in-servicing will be completed by October 31, 2011. The SRNAs, LPNs, and RNs were in-serviced on the importance of providing oral care to residents, and especially those residents who are dependent on staff to perform their ADLs. SRNAs, LPNs, and RNs were also in-serviced by October 31, 2011 by the Educational Director regarding the importance of brushing teeth at least twice a day, and as needed for those residents that are totally dependent on staff to provide their ADL care and are NPO and/or have a G-tube. If a resident who is total dependent on staff for ADLs refuses to have their teeth brushed the SRNA is to inform the nurse for that</p>	
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F 312	Continued From page 2 nor had he/she been offered to brush his/her teeth. Interview with Licensed Practical Nurse (LPN) #1, on 09/29/11 at 2:46 PM, revealed she had noticed Resident #2's teeth and she was not aware of Resident #2 ever seeing a dentist while at the facility. LPN #1 further stated, the white build-up could be from not cleaning Resident #2's teeth in such a long time. Interview with CNA #2, on 09/29/11 at 3:01 PM, revealed she was aware of Resident #2's teeth and she stated Resident #2 complained of tooth pain. She was unaware of Resident #2 ever having refused oral care and was not sure if Resident #2 received oral care that day, because she did not give the shower for the day. CNA #2 further stated, she did not make any nurses aware of Resident #2's dental pain. Interview with the Interim Director of Nursing (DON), on 09/29/11 at 3:44 PM, revealed oral care should be completed at least three (3) times a day or after meals. The Interim DON stated she was not aware of any issues with Resident #2's teeth. The interim DON felt Resident #2 could answer questions appropriately and when she was made aware of Resident #2's response about not receiving oral care, the Interim DON stated it was unacceptable.	F 312	resident immediately. The nurse for that resident will approach the resident to brush the resident's teeth. If a resident complains of mouth pain the SRNAs were in-serviced by October 31, 2011 by the Educational Director to notify the residents nurse immediately. The nurses were in-serviced by October 31, 2011 by the Educational Director to assess the mouth pain and treat appropriately. If the mouth pain needs to be referred to a dentist the social service department will be notified so they can make a referral to the dentist. Residents who are identified according to their care plan that they are dependent on staff to perform their ADLs, those residents' teeth brushing needs will be added to the Treatment Administration Record (TAR) that will be signed off by the residents nurse indicating the teeth were brushed. The SRNA care plan will also have to be signed off by the SRNA assigned to that resident	
F 502 SS=F	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		



ensuring that oral care has been provided. The facility policy for teeth brushing was updated on September 30, 2011 to reflect that resident that are NPO and/or have G-tube will have their teeth brushed at least twice a day and as needed (PRN).

4. To ensure this activity is being carried out the nurse assigned to a resident that is totally dependent on staff for ADLs with the need for teeth brushing will audit each shift that the teeth have been brushed. This will be recorded in the residents treatment administration record (TAR). A copy of the TAR will be forwarded to the Quality Assurance committee for review. Weekly the unit coordinator will audit teeth of the residents that are totally dependent on staff for ADLs. They will look for build-up, cleanliness, odor, and/or areas of mouth concern. The unit coordinator will also review the resident's TAR daily to ensure their teeth have been brushed. Any concerns the unit coordinator finds will be addressed immediately with the residents SRNA and/or nurse of that resident. The concerns noted by the unit coordinator will be forwarded to the Quality Assurance committee in a written report. Weekly in the morning meeting the social service department will review with the unit coordinators the need for a dentist of residents who are total dependent on staff for all ADLs. The social service director will submit a list to the Quality Assurance Committee of resident who need to be seen or who have been seen by the dentist.

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F 502	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy titled Lab Supplies, it was determined the facility failed to ensure laboratory supplies were ready for use by not monitoring laboratory supplies for expiration dates on two (2) of the two (2) nursing units. Observations revealed a total of thirty-seven (37) expired Hemocult screens, seven (7) expired yellow top specimen collection tubes, six (6) expired green top specimen collection tubes, and one (1) expired culture swab.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Lab Supplies, dated 04/2010, revealed it was the responsibility of the individual drawing the lab to ensure that the needed supplies were not expired and in proper condition prior to initiating the procedure. Expired or damaged supplies would be discarded by the person performing the procedure.</p> <p>Observation of the A hall medication room, on 09/29/11 at 3:00 PM, revealed twenty-three (23) hemocult screens which had expired 05/2009 and fourteen (14) hemocult screens which had expired 08/2011 leaving no available hemocult screens available for use. In addition, the observation revealed a yellow top specimen collection tube which expired 10/2010 and another yellow top specimen collection tube which expired 08/2011.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 09/29/11 at 3:05 PM, revealed expired</p>	F 502	<p>F 502: Facility Plan of Correction Completion date November 4, 2011</p> <ol style="list-style-type: none"> 1. The facility took specific measures to correct the violations on September 29, 2011. All outdated laboratory supplies that were in the facility were disposed of immediately on September 29, 2011 by the unit coordinators. Also on September 29, 2011 the hemocult screens which were expired were removed from the facility immediately by the DON. On September 29, 2011 our sister facility brought in appropriately dated hemocult screens for the facility to use until the facilities new supply arrived. 2. No out dated supplies were used on any resident of the facility. The unit A and unit B medication rooms and clean utility rooms were cleaned out on September 29, 2011 by the unit coordinators and DON to remove any out dated laboratory supplies. The medical supply room was also cleaned out by the facility medical supply clerk on September 30, 2011 of any out dated medical laboratory and or medical supplies. 	
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F 502	<p>Continued From page 4</p> <p>laboratory supplies could cause inaccurate results. LPN #2 revealed Central Supply should have been checking the expiration dates and should have more hemocult screens in central supply.</p> <p>Interview with Central Supply, on 09/29/11 at 3:20 PM, revealed nursing was responsible for ordering their own lab supplies and items were delivered by the lab company. The Central Supply revealed there were no hemocult screens or other lab supplies available for use in the central supply area.</p> <p>Observation of the clean utility room on the A unit, on 09/29/11 at 3:30 PM, revealed a yellow top specimen collection tube which expired 08/2011, a yellow top specimen collection tube which expired 05/2011, a green top specimen collection tube which expired 08/2011, and a culture swab which expired 08/2011.</p> <p>Interview with the A Unit Manager, on 09/29/11 at 3:30 PM, revealed the unit manager was responsible to check the lab supplies. The Unit Manager stated all nurses should be checking for expiration dates before performing a procedure. The Unit Manager revealed expired laboratory equipment could potentially cause a resident to be treated incorrectly due to an incorrect lab result.</p> <p>Observation of the clean utility room on the B hall, on 09/29/11 at 3:45 PM, revealed five (5) grey top specimen collection tubes which expired 04/2011 and three (3) yellow top specimen collection tubes which expired 08/2011.</p>	F 502	<p>3. All nurses will be in-service by the educational director to be completed by October 31, 2011 on the importance of discarding out dated laboratory supplies immediately. The supply clerk was inserviced by the DON on September 29, 2011 on the importance of knowing when hemocult screens and other medical supplies with expirations dates will expire. Also at that same time the DON inserviced the supply clerk on the importance of if an expired medical supply is found that it needs to be disposed of properly immediately. The DON was inserviced by a DON of a sister facility September 29, 2011 on the companies system to ensure laboratory supplies are monitored. The facility Laboratory Supply policy and Medical Supply policy was as updated on October 7, 2011.</p> <p>4. Weekly the unit coordinators for Unit A and Unit B will audit the dates of the facilities laboratory supplies that are kept in the unit medication rooms and clean utility room to ensure all products are within the appropriate date. Any items that will become out of date</p>	

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F 502	<p>Continued From page 5</p> <p>Interview with LPN #3, on 09/29/11 at 3:50 PM, revealed she was not aware who was responsible to monitor the laboratory supplies for expiration dates. The LPN revealed all hemocult screens were kept on the A hall. The LPN further revealed a potential for inaccurate lab results which could cause a resident to be medicated inappropriately.</p> <p>Interview with the Director of Nursing (DON), on 09/29/11 at 4:05 PM, revealed nursing should have been checking the dates of laboratory supplies prior to performing a procedure. The DON revealed she was not aware if there was a system in place to ensure the laboratory supplies were monitored for expiration dates and that supplies were available and ready for use.</p>	F 502	<p>within the next ten (10) days will be moved to the front of the supply to ensure use prior to expiration. Any items found to be out of date will be removed immediately and disposed of appropriately. Any product that is disposed of will be documented on an "out dated supplies" form. The Out Dated Supplies form will be forwarded to the Quality Assurance committee for review. When Medlab (the contracted laboratory for the facility) delivers supplies the unit coordinator for Unit A will review the laboratory supplies to ensure non-expired supplies are delivered. Weekly the supply clerk will audit the date of the supply of hemocult screens and the facility medical supplies kept in the facility supply room. Any hemocult screen or other medical supply found to be expired will be properly disposed of immediately. Any product that is disposed of will be documented on an "out dated supplies" form. The Out Dated Supplies form will be forwarded to the Quality Assurance committee for review. Monthly the DON will audit the medication rooms on Unit A and Unit B to</p>	
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ensure there are no out dated laboratory supplies or other medical supplies out of date. If an out dated laboratory supply, hemocult screen or other facility medical supply is found to be out of date the DON will remove the product immediately and dispose of it appropriately. Any product that is disposed of will be documented on an "out dated supplies" form. The Out Dated Supplies form will be forwarded to the Quality Assurance committee for review.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1997, 2000</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V unprotected.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 09/28/11. The Richwood was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty (120) beds and the census was eighty-nine (89) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>K-062 Facility Plan of Correction Completion Date October 14, 2011</p> <ol style="list-style-type: none"> 1. The facility took specific measures to correct the violations on September 28, 2011. The company that services the facilities sprinkler system (Brown Sprinkler Corporation) was notified by the maintenance director immediately on September 28, 2011 to bring the facility a sprinkler head wrench. The wrench was delivered the following day September 29, 2011. 2. The maintenance director placed the new sprinkler head wrench in the spare sprinkler head cabinet. The maintenance director also obtained an additional sprinkler head wrench to keep in the administrator's office to ensure there was a back up wrench. On July 21, 2011 Brown Sprinkler Corporation was in the facility doing a routine maintenance check. It is believed at that time one of the sprinkler service men accidentally took the sprinkler wrench with him. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Elisia Inesi</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 10/20/11</i>
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K 000	Continued From page 1	K 000	3. The maintenance director was in-serviced by the administrator on September 29, 2011 on the importance of having a sprinkler wrench available in the sprinkler head cabinet. The maintenance director was also in-serviced at that same time by the administrator on the importance of having a back up to the sprinkler wrench. In the future the maintenance director will inspect the area prior to the service man leaving to ensure all facility required equipment is left in its proper place.	
K 062 SS=D	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was eighty-nine (89) on the day of the survey. The findings Include: Observation, on 09/28/11 at 10:15 AM, with the Maintenance Director and the Environmental Services Director revealed the facility failed to provide a sprinkler head wrench per NFPA requirements. Interview, on 09/28/11 at 10:15 AM, with the Maintenance Director and the Environmental Services Director revealed they were unaware the sprinkler wrench was missing from the spare sprinkler head cabinet.	K 062	4. Weekly starting the week of October 3, 2011 the maintenance director will visually check, and ensure that the sprinkler wrench is in the spare sprinkler head cabinet. Monthly starting with the month of October 2011 when the administrator does life safety facility rounds the placement of the sprinkler wrench in the spare sprinkler head cabinet will be verified. If for some reason the extra sprinkler wrench that is located in the administrator's office has to be removed the maintenance director and/or administrator will be notified immediately. The	

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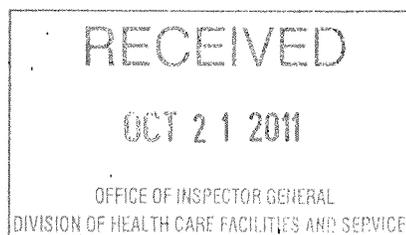
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2011
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 062	Continued From page 2 Reference: NFPA 13 (1999 edition) 6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.	K 062	administrator's monthly life safety rounds will be submitted to the Quality Assurance Committee for review.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, It was determined the facility failed to maintain doors within a required means of egress, per NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately forty (40) residents, staff, and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was eighty-nine (89) on the day of the survey. The findings include: Observations, on 09/28/11 between 8:30 AM and 11:30 AM, with the Maintenance Director and the Environmental Services Director revealed unapproved locks (slide bolt and padlock types) were installed on three (3) doors within the facility. 1. A slide bolt on the door to the ice machine	K 130	K-130 Facility Plan of Correction Completion Date November 3, 2011 1. The facility took specific measures to correct the violations on September 28, 2011. The unapproved locks that were on the three (3) doors (ice machine room, Wound Care Room, and kitchen dry storage) were removed immediately on September 28, 2011 by the maintenance director. 2. The maintenance director did an immediate audit on September 28, 2011 of all other doors in the facility to ensure there were no other prohibited locks on any facility doors. There were no other doors in the facility with prohibited locks on them. The maintenance director ordered the new locks on October 3, 2011. The kitchen dry storage lock was installed on October 5, 2011 by the maintenance director. The wound nurse had approved locks installed on her filing cabinets and	



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K 130 Continued From page 3
room in the 400 Hall.
2. A padlock on the door to the Wound Care Room at Nurses Station B.
3. A padlock was installed on the door to the kitchen storage room.

Interviews, on 09/28/11 between 8:30 AM and 11:30 AM, with the Maintenance Director and the Environmental Services Director revealed they were aware of the locks installed on the door; however they were not aware the locks were prohibited.

Reference: NFPA 101 (2000 Edition)

19.2.2.2.4
Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

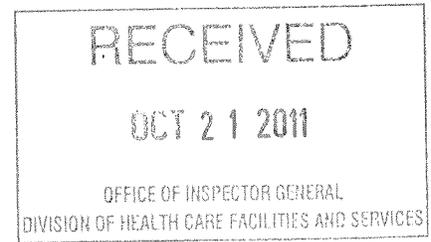
K 147 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty (120) beds

K 130 at this time the wound care office has been left unlocked. The ice machine room has been left unlocked.

3. The maintenance man was in-serviced by the administrator on September 29, 2011 on the proper type of locks to use on doors within the facility. In the future prior to the maintenance man installing a lock on a door in the facility he will have to obtain written permission from the administrator. The facility policy was updated on October 3, 2011 to reflect the administrator approval prior to the installation of a lock to a facility door.

K 147 4. Starting October 7, 2011 the administrator will audit facility doors monthly during life safety rounds to ensure no unapproved locks are on any doors in the facility. When and if a new lock is installed the administrator will review the new installation within one week of the lock being installed. This review will be to ensure that the proper lock was installed. Any noted issues with inappropriate locks will be written up by the administrator and issued to the



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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
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K 147	Continued From page 4 and the census was eighty-nine (89) on the day of the survey. The findings include: Observations, on 09/28/11 between 8:30 AM and 11:30 AM, with the Maintenance Director and the Environmental Services Director revealed: 1. Electrical panels located in resident halls 100, 200, 300, 400, 500 and 600, were unlocked. 2. A small refrigerator was plugged into a power strip in resident room 106. Interviews, on 09/28/11 between 8:30 AM and 11:30 AM, with the Maintenance Director and the Environmental Services Director revealed they were not aware of the requirement that electrical panels, located in the resident corridors, were to be locked. They were unaware a power strip was being used to power a small refrigerator in a resident's room. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	K-147 Facility Plan of Correction Completion Date October 31, 2011 1. The facility took specific measures to correct the violations on September 28, 2011. The maintenance director immediately ordered electric panel locks on September 28, 2011 to be installed on the electric panel covers. Immediately on September 28, 2011 the small refrigerator that was in a resident's room was unplugged from the surge protector and plugged into a wall outlet by the maintenance director. 2. The electric panels located in the residents halls 100, 200, 300, 400, 500 and 600 did not have locks installed on them from the manufacture, therefore locks had to be obtained from a supplier. The locks for the electric panels arrived at the facility on October 11, 2011 and the maintenance director installed the locks that date October 11, 2011 on all electrical panels that are in resident areas on halls 100, 200, 300, 400, 500 and 600. After the locks were installed the electric panels all electric panels located in resident halls 100, 200, 300, 400, 500 and 600 were locked.	

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OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2011
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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K 147	<p>Continued From page 5</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>An immediate audit on September 28, 2011 was conducted by the maintenance director and environmental services director of all residents' rooms who have small refrigerators. Any refrigerator found to not be plugged into a wall outlet was corrected immediately.</p> <p>3. The maintenance director and environmental service director were inserviced by the administrator on September 29, 2011 regarding the importance of the electrical panels located in the resident halls have to be locked at all times. At that time the maintenance director and environmental service director were inserviced on the proper outlet for a resident's refrigerator to be plugged into. Also the importance of ensuring the residents refrigerator is approved by the administrator or</p>	
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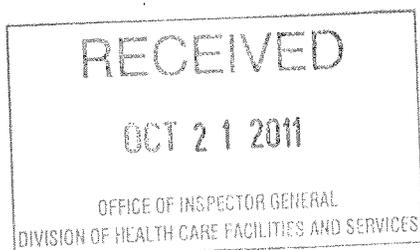
OCT 21 2011

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maintenance director. The facility policy regarding resident's refrigerators was updated October 4, 2011.

A list was compiled by the Environmental Service Director on September 29, 2011 of resident with refrigerators in their rooms. This list was given to Unit A and Unit B nurse coordinators, Environmental staff and the administrator. An all staff in-service will be completed by the administrator by October 31, 2011 on the importance of ensuring that the residents refrigerators are plugged into a wall outlet and not a surge protector. At that same time by October 31, 2011 staff was/will be in-service by the administrator regarding a reminder that if they see families bring refrigerators into the facility that they have to be approved by the administrator and/or the maintenance director prior to being put into the resident's room.

4. Weekly starting October 17, 2011 the environmental services director will audit the room of each resident that has a refrigerator in the room to ensure that the refrigerator is plugged into a wall outlet. If a resident brings in a new and or replacement refrigerator the maintenance director or administrator will be present when the refrigerator is plugged into an electrical source to ensure it is plugged into a wall outlet. If this is the first time the resident has a refrigerator or if it is a new admission the resident's name will be added to the list of residents who



have refrigerators in their room. This list will be maintained by the environmental service director. Weekly starting October 17, 2011 the environmental service director will ensure that the electric panels located in resident halls 100, 200, 300, 400, 500, and 600 are locked.

Monthly starting in October when the administrator does life safety code rounds of the facility the administrator will enter the room of each resident that has a refrigerator to ensure the refrigerator is plugged into a wall outlet. Also on the administrators monthly life safety code rounds starting in October 2011 the electrical panels located in resident halls 100, 200, 300, 400, 500 and 600 will be checked to ensure they are locked. The administrator's monthly life safety rounds will be submitted to the Quality Assurance Committee for review.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1997 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF Type of Structure: A 1997 one story, Type V (111) protected combustible wood frame construction with a complete automatic (dry) sprinkler system and a total of five smoke compartments. A Comparative Federal Monitoring Survey was conducted on 11/16/11, following a State Agency Annual Survey on 09/28/11 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, The Richwood was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000	POC ACCEPTED DEC 07 2011 <i>lll</i> K-029: Facility Plan of Correction Completion Date December 10, 2011 1. The Facility took specific measures to correct the violations on November 16, 2011. The 200 hall storage room corridor door had a self closer placed on the door at 4:30 p.m. on November 16, 2011. 2. On November 16, 2011 the maintenance director conducted a 100% audit of the facilities fire doors to ensure that all fire doors are equipped with self-closers. 3. The maintenance director was in-serviced by the administrator on November 17, 2011 of the importance of ensuring all fire doors are equipped with self-closers. The maintenance director was also in-serviced by the administrator on November 17, 2011 on the importance of evaluating the integrity of each fire door during monthly quality assurance rounds.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Elesia M. ...* TITLE *Administrator* (X6) DATE *12-2-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to separate hazardous areas from other areas in the facility. The deficient practice affected one of five smoke compartments, staff and 20 residents. The facility has the capacity for 120 beds with a census of 98 the day of survey. Findings include: Observation on 11/16/11 at 10:45 a.m. revealed that the corridor door to the 20D hall storage room was not equipped with a self-closing device. The room was in excess of 50 square feet and had paper files and combustible storage in cardboard boxes on open shelves. Interview with the facility Maintenance Supervisor on 11/16/11 at 10:45 a.m. revealed the facility was not aware that the self-closing device had been removed from the door to the storage room. Actual NFPA Standard: NFPA 101, 19.3.2.1. Hazardous areas shall be safeguarded by a fire barrier of one-hour fire resistance rating or provided with an automatic sprinkler system. The doors shall be self-closing or automatic-closing. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors.	K 029	4. Weekly starting November 28, 2011 during the maintenance physical plant rounds the maintenance director will review the fire doors to ensure they are equipped with self-closers. If a door is found to be out of compliance the maintenance director will address the issue immediately. Any fire door found to have compliance issues in regards to NFPA 101, 19.3.2.1. will be reported to the administrator, and the quality assurance committee. The quality assurance committee will receive their first report in December for the findings in November. The administrator will be given the physical plant report from the maintenance directors' weekly audit and follow up with any stated issues to ensure that the fire doors are in compliance with NFPA Standard: NFPA 101, 19.3.2.1.	